DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2003 — 20

2. STATE: Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.225, 42 CFR 440.120(d)

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ (1,460)
b. FFY 2004 $ (5,770)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, Pages 4,5, 34 and 35
Attachment 3.1-B, Pages 4, 5, 32 and 34
Attachment 4.18-A, Page 1
Attachment 4.18-C, Page 1
Attachment 4.19-B, Pages 26 and 27

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A, Pages 4, 5, 34, 35, 36
Attachment 3.1-B, Pages 4, 5, 32, 33, 34
Attachment 4.18-A, Page 1
Attachment 4.18-C, Page 1
Attachment 4.19-B, Pages 26, 27

10. SUBJECT OF AMENDMENT:
Modifications in the Adult Hearing Services and Adult Visual Services Programs

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Comments will be forwarded when received

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bob Sharpe

13. TYPED NAME:
Mr. Bob Sharpe

14. TITLE:
Deputy Secretary for Medicaid

15. DATE SUBMITTED:
9/8/03

16. RETURN TO:
Mr. Bob Sharpe
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, Florida 32308

ATTN: Kay Newman

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 9, 2003

18. DATE APPROVED:
November 10, 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
R. L. Mason for Susan Cuerdon

21. TYPED NAME:
Susan Cuerdon

22. TITLE:
Acting Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations* (7-1-85)

/ / Not provided.

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations* (6-1-75)

/ / Not provided.

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations* (7-1-80)

/ / Not provided.

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations* (7-1-80)

/ / Not provided.

d. Eyeglasses.

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on attachment.

10/1/97 (12d) Eyeglasses/Contact Lenses

For non-EPSDT recipients twenty-one years of age and older, contact lenses will be provided for limited conditions, and require prior authorization. Eyeglasses are not covered. Prosthetic eyes and services related to measuring, fitting and dispensing are reimbursed. Service limitations for EPSDT recipients are listed in the EPSDT section.

Amendment 2003-20
Effective 7/1/03
Supersedes 97-18

Approval NOV 10, 2003

10/1/90 (11c) HEARING SERVICES: For non-EPSDT recipients 21 years of age and older, services are not covered. Refer to the EPSDT section for EPSDT limitations.

State/Territory: FLORIDA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

8. Private duty nursing services.

[X] Provided: [ ] No limitations [X] With limitations*

9. Clinic services.

[X] Provided: [ ] No limitations [X] With limitations*

10. Dental services.

[X] Provided: [ ] No limitations [X] With limitations*

11. Physical therapy and related services.

a. Physical therapy.

[X] Provided: [ ] No limitations [X] With limitations*

b. Occupational therapy.

[X] Provided: [ ] No limitations [X] With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not provided

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

[X] Provided: [ ] No limitations [X] With limitations*

b. Dentures.

[X] Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

State/Territory: FLORIDA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

c. Prosthetic devices.

[X] Provided: [ ] No limitations [X] With limitations*

d. Eyeglasses. [X] Not provided

[ ] Provided: [ ] No limitations [ ] With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

[X] Provided: [ ] No limitations [X] With limitations*

b. Screening services.

[X] Provided: [ ] No limitations [X] With limitations*

c. Preventive services. NOT PROVIDED

[ ] Provided: [ ] No limitations [ ] With limitations*

d. Rehabilitative services.

[X] Provided: [ ] No limitations [X] With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services. NOT PROVIDED

[ ] Provided: [ ] No limitations [ ] With limitations*

b. Nursing facility services. NOT PROVIDED

[ ] Provided: [ ] No limitations [ ] With limitations*

*Description provided on attachment.

10/1/90 (11c) HEARING SERVICES: For non-EPSDT recipients 21 years of age and older, services are not covered. Refer to the EPSDT section for EPSDT limitations.

10/1/97 (12d) Eyeglasses/Contact Lenses

For non-EPSDT recipients twenty-one years of age and older, contact lenses will be provided for limited conditions, and require prior authorization. Eyeglasses are not covered. Prosthetic eyes and services related to measuring, fitting and dispensing are reimbursed. Service limitations for EPSDT recipients are listed in the EPSDT section.

Amendment 2003-20
Effective 7/1/03
Supersedes 97-18

Approval NOV 10, 2003

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State FLORIDA

a. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge			Amount and Basis for Determinations
	Deduct.	Coins.	Copay	

TN No. 03-20
Supersedes
TN No. 02-11

Approval Date NOV 10, 2003

Effective 7/1/03

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State FLORIDA

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge			Amount and Basis for Determinations
	Deduct.	Coins.	Copay	

METHODS USED IN ESTABLISHING PAYMENT RATES

10/1/90 EYEGLASSES/CONTACT LENSES – Reimbursement for contact lenses is based on a fee schedule established by the state agency.

METHODS USED IN ESTABLISHING PAYMENT RATES

10/1/90 HEARING AIDS – No longer provided.